2001 N. MacArthur Blvd. Suite 335
Irving, TX. 75061
Tel: (214) 716 – 7573 Fax: (888) 657 - 4737

Name: ________________________________ Date of Birth: _____________________

AUTHORIZATION TO COMMUNICATE THROUGH VOICE MAIL, EMAIL, TEXTING, APPS AND OTHER FORMS OF COMMUNICATION:

I authorize Signature Kidney Care PLLC to leave messages about my private health information on my home answering machine, voicemail, email, text messages.

AUTHORIZATION TO COMMUNICATE YOUR MEDICAL CONDITION WITH SPECIFIC INDIVIDUALS:

I understand that without my explicit permission, Signature Kidney Care PLLC is not permitted to speak with family members, friends, and other non-medical persons about my care.

I authorize Signature Kidney Care to share my medical information with the following individual who may communicate with others at my discretion.

Name: ________________________________ Relation: ______________________

Email: ________________________________ Tel: ____________________________

I understand I have the right to withdraw this consent, in writing, at any time **except where Signature Kidney Care PLLC has already made a disclosure based on my past consent**.

Signature of Patient ____________________________ Date: _________________

Print Name: ____

Signature of guardian if the patient is unable to sign ______________________________

Print Name: __________________________________ Date: ________________________